



Marin County Continuum of Care

Standard HMIS Child Client Status Update and/or Annual Assessment

Program Name: _____ Case Worker/Intake Person: _____ Date: _____

CLIENT STATUS UPDATE/ANNUAL ASSESSMENT

Status Update Assessment is to be filled out every time there is a change in disabilities, income, non-cash benefits, or health insurance.

Annual Assessment is to be filled out once a year – 30 days before or after the anniversary of the program start date.

Separate client Status Update and/or Annual Assessments should be completed for each child client *as long as they are not the Head of Household*. **A separate Status Update and/or Annual Assessment form must be completed for adult household members, but please be sure to use the Standard Adult Client Status Update and/or Annual Assessment form.**

1) Client Name	First	Last
2) Project Status Update or Annual Assessment Date	/ / Month Day Year	
DISABLING CONDITIONS: A Disabling Condition is a health condition that interferes with getting and/or keeping stable housing.		
1) Does the client have a Physical Disability?	☐ Yes ☐ No	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data Not Collected
<i>If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?</i>	☐ Yes ☐ No	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data Not Collected
2) Does the client have a Developmental Disability?	☐ Yes ☐ No	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data Not Collected
3) Does the client have a Chronic Health Condition?	☐ Yes ☐ No	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data Not Collected
<i>If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?</i>	☐ Yes ☐ No	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data Not Collected

Client Name _____

Head of Household Name (if not Self) _____

4) Does the client have HIV – AIDS?	☐ Yes ☐ No	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data Not Collected
5) Does the client have a Mental Health Disorder? <i>If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?</i>	☐ Yes ☐ No	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data Not Collected
	☐ Yes ☐ No	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data Not Collected
6) Does the client have any Substance Use Disorder? <i>If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?</i>	☐ No ☐ Alcohol use disorder ☐ Drug use disorder ☐ Both Alcohol & Drug Abuse Use Disorders	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data Not Collected
	☐ Yes ☐ No	☐ Client doesn't know ☐ Client prefers not to answer ☐ Data Not Collected

HEALTH INSURANCE

Currently covered by health insurance? <i>Is the client currently covered by health insurance?</i> If Yes, type(s) of insurance(s): <i>If the client is currently covered by multiple health insurances please select all that apply.</i>	☐ Yes ☐ No ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data Not Collected ☐ Medicaid (same as Medi-Cal) ☐ Medicare ☐ State Children's Health Insurance (CHIP) Program ☐ Veteran's Health Administration (VHA) ☐ Employer-Provided Health Insurance ☐ Health Insurance Obtained Through COBRA ☐ Private Pay Health Insurance ☐ State Health Insurance for Adults ☐ Indian Health Services Program ☐ Other Health Insurance If Other Specify: _____
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Client Name _____

Head of Household Name (if not Self) _____